Building Community Partnerships for Cancer Prevention & Control Initiatives

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Definitions of Health

- “Health is a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.” (WHO, 1946)
- “Health just does not mean the physical well-being…but refers to the social, emotional, spiritual and cultural well-being of the whole community.” (NHMRC, Canberra Australia, 1996)

Health Care Disparities

“There has long been recognition of racial disparities in cancer treatment and survival...Our results suggest that racial disparities in ovarian cancer are not due to underlying biological differences rather to unequal application of existing treatments.”

In Baltimore, 5 miles makes a world of difference...

Roland Park:
• $90,492 in income
• 3.4% unemployment
• 83.1 year life expectancy
• 4.1/10,000 homicide rate

Madison/East End:
• $30,389 in income
• 14.4% unemployment
• 64.8 year life expectancy
• 46.3/10,000 homicide rate

Investigating Cancer Disparities Across the Cancer Prevention & Control Continuum
The Johns Hopkins Center to Reduce Cancer Disparities (JHCRCD)
Baltimore, Maryland

Our Vision: All communities should have equal access to quality cancer services for prevention, early detection, treatment, and survivorship.

Our Mission: The JHCRCD is committed to reaching multiracial and ethnic communities for outreach, education, training, and research in partnership with our Community Advisory Groups in Baltimore City and Prince George’s County and over 100 community agencies and organizations.

Primary Prevention
- Baltimore Household Smoking Cessation Project
- HPV Project

Secondary Prevention
- UO1 - Project LUSTER
- Evaluating Coaches of Older Adults for Cancer Care and Healthy Behaviors (COACH)
- Reducing Distress & Increasing QOL Among Newly Diagnosed Lung Cancer Patients
- MERCK - Increasing Access to Quality Cancer Care for Underserved Populations

Tertiary Prevention

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Urban Community Priorities
• Crime
• Housing
• Employment
• Nutrition
• Education
Cancer Mortality in the U.S.
- In 1990, the State of Maryland ranked first in the U.S., and the State of Delaware was second until 1995
- As a jurisdiction, Washington, DC was actually first
- When Baltimore City was compared to Washington, DC, the rate was 15% higher
- Today, Maryland is now 30th in the U.S.

Needs-Driven vs. Asset-Based

Needs-Driven
- Endless list of problems and needs that results in fragmentation
- Funding goes to service providers
- Suggests that only outside experts can help
- Ensures dependency
- Rarely brings about significant change

Asset-Based
- Begins with identification of capacities and resources
- Focuses internally to emphasize the importance of local definitions, investments, creativity, hope, and control
- Emphasizes relationship among residents, associations, organizations, and institutions

THE CASE
- A woman lived 6 blocks from one of the best cancer centers in the U.S.
- Came to the Emergency Room in severe pain
- Examination revealed a stage IV breast tumor with metastatic disease
- Determined to be terminally ill
- Referred for hospice care
Barriers to Health & Preventive Health

5 A’s of Health Care

• Availability
• Accessibility
• Acceptability
• Affordability
• Accountability

Breast & Cervical Cancer Screening Program

• Funding via the Health Services Cost Review Commission in 1992
• Screened over 20,000 women
• 86%- African American, 68%- high school education or less, 54% uninsured
• Over 100 women diagnosed with breast cancer and treated
• Site for Drs. Candace Morrison’s and Ann Klassen’s studies

Recruitment Strategies

• Must understand that day-to-day survival takes precedence over most other issues
• Possibility of a condition 10 years in the future is of less importance than shelter, clothing, and food
• Culturally-sensitive strategies, personalized care, and vigilant follow-up are essential
• A multidisciplinary team is critical for a successful screening program

• Zabora, Morrison, Olsen & Ashley, 1997.

Breast & Cervical Cancer Screening Program

• Attendees identified more than 70 locations where they received information about the program
• Women using the no-cost program at least once were generally more poorly screened than their community controls
• Women using the no-cost program had a better recent screening history 3 years after the program began
• Attendees were more likely to have less than $10K income, more children, and less likely to have health insurance

**Reaching the Poorest of the Poor for Mammography Screening**

- 70% reported incomes below $6,000
- Achieved a 50% screening rate in a very low-income population by a targeted intervention
- Knowledge of breast cancer and mammography increased significantly between 2nd and 3rd assessments
- Perceived barriers also were reduced


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**State of Maryland Cigarette Restitution Fund**

- $4.4 billion settlement from TC to State to local jurisdictions
- One of the leading states for cancer mortality
- Under Public Health Component, 7 targeted cancers in underserved populations
- Reduction of mortality through early detection and treatment
- 10 years at $1.5 million/year (JHU and UMAB)
  - Dr. Jimmie Drummond

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**Baltimore City Cancer Coalition**

- 3 Town Hall Meetings across the city
- Of over 150 organizations that attended 1 or more meetings, the Coalition emerged as 125 CBOs that represented groups across Baltimore City
- Participated in the conceptualization of program and related services
- Focused on program development, program monitoring, and promotion of program

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**Prostate Cancer Mortality by Census Tract 1997 - 1999**

Kanarek et al, 2001
Community-Based Centers

- Bea Gaddy Family Center
- Garden Of Prayer Baptist Church
- Morgan State University
- Park Heights Community Health Alliance
- Urban Medical Institute
- Hispanic Apostolate
- Korean Resource Center

Elaboration Likelihood Model

- Knowledge
- Credibility
- Familiarity
- Trust

NOTE: If you wish to change behavior, the source of the message of change must have these traits.

“Improving Cancer Care for the Underserved in Academic and Community Practice Settings”

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Intervention 1B
Care Partner Training

- Outcomes from the COACH Study (n=1,106)
- Use of family members as care partners
  - Prefer family member vs. community resident
- Diagnostic phase pathway with MyChart
- Simultaneous training in issues during the early phase of treatment
- Emphasis on “problem-solving skills”
- Implementation by Community Health Worker
- Potential for small group training
- Pre- and post-assessments

Intervention 2B
Community Health Workers

- Access is built on familiarity and trust as well as being knowledgeable and credible
- Greatest barrier may be a complete medical record of all pertinent history and preliminary results prior to the first visit
- “Patient Flow Schematic”
- Outcomes are: Time to first appointment; Adherence with early appointments; MyChart registration; Frequency of MyChart utilization; Overall sense of satisfaction

Problem-Solving:
A Series of Specific Skills

1. Problem Orientation
   Reflects orientation to problems—negative and positive

2. Problem Definition and Formulation
   Clarify & Understand Specific Nature of Problem
   Specify Set of Realistic Goals & Objectives

3. Generation of Alternatives
   “Brainstorming” to Produce Effective Solutions

4. Decision-Making
   Conduct a Systematic Cost-Benefit Analysis of Each Solution Based on the Evaluation

5. Solution Implementation & Verification
   Carry out the Solution Plan, Monitor & Evaluate its Effectiveness

Zabora
Stress Model Theory

Person

Meaning

Action

Stressor

Internal Resources

External Resources

Personality
Mastery
Optimism
Spirituality
Problem-Solving
Family
Friends
Employer
Organizations

Lazarus & Folkman, 1984

Community Health Workers

• Outcomes & Measures
  – Psychological Distress (Chronic Illness Distress Scale-CIDS)
  – Health-Related Problems (Problem Checklist-PCL)
  – Problem-Solving Skills (Social Problem-Solving Index-SPSI)
  – Quality of Life (Satisfaction with Life Domains Scale-SLDSC)

• Assessment Points- “Time Series Design”
  – At first contact and 5-7 days later (2 assessment points prior to Interventions)
  – Follow-up at 4, 8, and 12 months

Intervention 3- Expand Stakeholder Engagement

• Regional Community Advisory Group (CAG) expansion
• Conduct a minimum of 10 CAG meetings/year
• Develop training for new CAGs in order to understand and evaluate project activities
• Recruit diverse stakeholders as CAG members
• Use of the CAGs to develop new and significant community resources
• Agendas for September through December ‘17
• Guided by the Alliance Steering Committee

Some problems are so difficult they can’t be solved in a million years unless someone thinks about them for five minutes.

H.L. Mencken
A difference is a difference only if it makes a difference.

Huff, 1954